covingtonsmiles

Patient Information

Date:_____ Patient Name:_____ Date of Birth:_____ Sex: ☐ M ☐ F

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other Social Security Number_____

Address:_____ City/State/Zip:_____

Billing Address (if different than above):_____ City/State/Zip:_____

Home Phone:_____ Cell Phone: _____ Email:_____

Employer and Occupation:_____ Work Phone:_____

Emergency Contact Name:_____ Emergency Contact Phone:_____

Whom may we thank for referring you:_____

Responsible Party

Name of person responsible for the account:_____ Phone:_____

Address of Responsible party:_____ City/State/Zip:_____

Relationship to the patient:_____ Birthdate:_____ SSN:_____

Insurance Information

Primary Insurance

Name of Subscriber:_____ Relationship to Patient: _____

Insured's Date of Birth:_____ SSN:_____ Employer:_____

Insurance Company:_____ Phone:_____

Member ID:_____ Group Number:_____

Secondary Insurance

Name of Subscriber:_____ Relationship to Patient: _____

Insured's Date of Birth:_____ SSN:_____ Employer:_____

Insurance Company:_____ Phone:_____

Member ID:_____ Group Number:_____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during a period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature of Patient or Guardian:_____ Date:_____

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Dental History

Reason for today's visit:_____ Last Dental Visit:_____

How often do you brush your teeth:_____ What texture do you use: Soft Medium Hard

Is there anything about your smile that you do not like:_____

What would you like to accomplish in your dental treatment:_____

Please check all that apply

- ☐ Do you have any old fillings or treatment that you are unhappy with
- ☐ Do your gums bleed while brushing
- ☐ Do your gums bleed when flossing
- ☐ Do you clench or grind your teeth
- ☐ Do you have frequent headaches
- ☐ Have you noticed any loosening of your teeth
- ☐ Does food tend to become caught between your teeth
- ☐ Do you have any sores or lumps in or near your mouth
- ☐ Have you ever had an upsetting experience in a dental office? If yes, please explain below:

_____
_____
_____

- ☐ Are your teeth sensitive to hot/cold/sweet/sour foods/liquids
- ☐ Would you like your teeth to be whiter
- ☐ Do you bite your lips or cheeks frequently

Have you ever had:

- ☐ Orthodontic Treatment (Braces)
- ☐ Oral Surgery
- ☐ Your teeth reshaped or bite adjusted
- ☐ Occlusal Guard/Night Guard
- ☐ Is there anything about having dental treatment that Concerns you? If yes, please explain below:

_____
_____

Have you ever experienced any of the following problems in your jaw:

- ☐ Clicking
- ☐ Pain (joint, ear, side of face)
- ☐ Difficulty opening/closing

Medical History

- ☐ Do you consider yourself to be in good health
- ☐ Have there been any changes in your general health within the past year? If yes, please explain below:

_____
_____

- ☐ Have you had any abnormal bleeding
- ☐ Have you been hospitalized for any surgical operation or serious illness? If yes, please explain below:

_____
_____

- ☐ Are you currently under the care of a physician
- ☐ Are you currently taking any medications including non prescription medications and blood thinners? If yes, please list below or provide us a copy of your medications to scan:

_____
_____
_____
_____
_____
_____

- ☐ Do you bruise easily

When was your last physical exam:_____
Physician's name:_____
Telephone:_____

- ☐ Do you have any disease, condition, or problem not listed above that you believe we should know about? If yes, please list below:

_____
_____

- ☐ Have you or are you currently taking Osteoporosis Medication such as Fosamax? If yes, please list below:

_____
_____

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Medical History Continued...

Please check all that apply

Are you allergic to or have had reactions to:

- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Barbiturates, Sedatives, Sleeping Pills
- ☐ Iodine
- ☐ Latex
- ☐ Red Dye #40
- ☐ Other, if yes please list below:

_____

_____

☐ Artificial Joints, if yes please list below with dates:

_____

_____

- ☐ Have CPAP or diagnosed with sleep apnea
- ☐ Have trouble sleeping
- ☐ Have pain in your chest upon exertion
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Have COPD
- ☐ Epilepsy or Seizures
- ☐ AIDS/HIV
- ☐ Sinus Trouble or Hay Fever
- ☐ Rheumatism/Osteoarthritis
- ☐ Recent Weight Loss
- ☐ Psychiatric Care
- ☐ Tuberculosis
- ☐ Have HPV 16 or 18
- ☐ Anemia

Do you use any of the following:

- ☐ Alcohol
- ☐ Cigarettes
- ☐ Chewing Tobacco
- ☐ Vape
- ☐ Marijuana
- ☐ Cocaine
- ☐ Other drugs, if yes please list below:

_____

☐ Cancer, if yes please list below with dates:

_____

_____

- ☐ Do you require a premed before dental appointments
- ☐ Heart Attack ☐ Heart Trouble ☐ Angina ☐ Stroke
- ☐ Heart Surgery ☐ Irregular Heartbeat ☐ Heart Murmur
- ☐ Heart Pacemaker/Defibrillator/Artificial Heart Valve
- ☐ Hepatitis B or C
- ☐ Liver Disease ☐ Kidney Disease ☐ Lung Disease
- ☐ Asthma: If yes, do you need inhaler? _____
- ☐ Diabetes: If yes, last A1C? _____
- ☐ Herpes
- ☐ Thyroid Problems
- ☐ Acid Reflux
- ☐ Hearing Impairment
- ☐ Stomach Ulcer
- ☐ Eating Disorder
- ☐ Persistent Cough, if yes please explain below:

_____

_____

Women Only

- ☐ Pregnant/Trying to get pregnant
- ☐ Taking Birth Control
- ☐ Nursing

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian_____ **Date**_____

Financial Agreement

Payment: Fees are established according to services performed and payment is due at the time of service unless prior arrangements have been made. (If you have dental insurance, we require that you pay your estimated portion and deductible at the time of service.) A finance charge of 1% per month 12% per annum is assessed on any balance after 60 days.
Insurance Payment: To prevent misunderstandings, we inform our patients that insurance policies vary and that it is each patient's responsibility to pay for the services rendered, regardless of individual coverage. We are happy to process your insurance claim for you if all necessary filing information has been provided to us.

You must realize, however, that:

1. Your insurance is a contract between you, your employee and the insurance company. We are not a party to that company.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

Thank you for your understanding. Please do not hesitate to let us know if you have any questions or concerns.

I understand and agree to the terms of this Financial Policy:

Signature:_____
Date:_____

HIPPA (Health Insurance Portability and Accountability Act

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Covington Smiles The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Covington Smiles reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐YES	☐NO
SPOUSE ONLY	☐YES	☐NO
OTHER (PLEASE SPECIFY)	☐YES	☐NO

Name of Patient_____
Date_____

Signature of Patient or Guardian/Parent_____